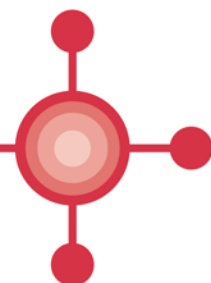


All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan



Persistent Pain Resources

Educational Slide Set

October 2016

This document has been prepared by a multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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Management of Persistent Pain



AWTTC
All Wales Therapeutics
& Toxicology Centre

Aims

Highlight the issues surrounding the management of persistent pain conditions and support patients, carers and healthcare teams in understanding the potential benefits and harms of medicines used in pain management.

Provide prescribers with the information needed to support the appropriate management of persistent pain conditions.

Highlight the risks associated with inappropriate prescribing of medicines in pain management.

Definitions

Pain

"Pain is an emotion experienced in the brain, it is not like touch, taste, sight, smell or hearing. It is categorised into Acute pain - less than twelve weeks duration and Chronic pain - of more than twelve weeks."

Pain can be perceived as a warning of potential damage, but can also be present when no actual harm is being done to the body."

British Pain Society

www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Neuropathic pain

"Neuropathic pain is pain initiated or caused by a primary lesion or dysfunction in the peripheral or central nervous system. For example, pain following shingles, or an amputation, or spinal cord trauma. Pain that occurs in diabetics or in patients with multiple sclerosis can also be neuropathic."

British Pain Society

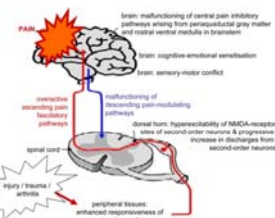
www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Persistent Pain

•Persistent pain is complex and can be described as having both sensory and emotional components

•The only way of deciding whether someone has pain is by asking them or picking up clues from the way they behave

•There must be a patient-centred holistic approach to persistent pain management



Persistent Pain

Medicines in general and opioids in particular are often not very effective for persistent pain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must be considered within a wider social context, and issues such as diversion must be addressed

Different treatments work for different people



Managing expectations

Not likely to be cured

Not likely to be pain-free

Need to self-manage as with any other chronic condition

Patient needs to be party to the treatment and to take control/responsibility for some of their care



Background

Persistent pain is complex

Opioids are increasingly being used to treat persistent pain

Opioids have a well-established role in the management of acute pain and in the management of pain in terminal illness

However, the safety and efficacy of opioids in the long-term, as well as the risk of tolerance, dependence and addiction, is uncertain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must also be considered within a wider social context and issues such as diversion and misuse must be addressed



Ten Key Messages - Managing Persistent Pain

1. Ongoing pain is often down to changes in the processing of pain, not because of a complication or an underlying pathology.
2. Not every opioid will be effective for every patient.
3. Further investigations may be necessary, but it is important to ensure that nothing may not always be related to the pain.
4. The **Non-pharmacological Management (NPM) pack** was developed for cancer pain, and while it is useful for chronic pain, it is not designed for ongoing pain. Using the NPM pack in ongoing pain should be stopped before a strong opioid is used.
5. Establishing whether or not the pain has a neurophysiological component may help when thinking about a management plan.
6. Managing persistent pain is about effective management and not about finding a cure. It is with any other chronic condition, it is important to ensure that the patient copes with their pain better. The **British Pain Society** provides useful [resources](#).
7. The **Non-pharmacological Management (NPM) pack** and **opioid pack** may be useful to help patients to self-manage.
8. Being active is very important for the best pain outcomes. It is more painful to be inactive, and a vicious cycle often.
9. Good writing, pacing and planning are useful strategies for managing a pain problem.
10. It is OK to say that nothing more can be done in the patient's terms of medical treatment. It may not be helpful to give the patient false hope with further treatment, and instead, looking for an alternative. However, continued support with self-management strategies is essential.



Non-pharmacological management of persistent pain

Non-pharmacological therapies and medicines with proven efficacy for persistent pain syndromes should always be tried before starting opioids



Ten Key Messages - Non-pharmacological Management

1. Refer to a multidisciplinary team including professionals such as physiotherapists, occupational therapists, and nurses experienced in managing pain and contribute to the non-pharmacological management of persistent pain by a shared pain management and functional outcomes programme.
2. Persistent pain should be assessed and managed using a **biopsychosocial model**. Psychological factors have a significant impact on disability and outcomes.
3. Biomedical factors often do not explain the severity of symptoms or disability.
4. Supporting self-management is a core component of self-management, including people that have persistent pain. Self-management and self-care tools.
5. Good exercise and keeping active is effective at helping to manage persistent pain.
6. Evidence has found that self-management support can be more effective in groups across individual settings, for example, **Manual Handling** and **Coaching**, [Resources for Patients](#).
7. Cognitive Behavioral Therapy (CBT) can be effective in helping to manage persistent pain. It is important to use the **CBT pack** delivered by appropriately trained and skilled practitioners.
8. Assessment of this should not be a challenge for people with persistent pain. **Manual Handling** and **Coaching** and **Coaching** Therapy (ACT) can help with this. Consider referral to a physiotherapist or other appropriately accredited professional.
9. Consider referral to a physiotherapist who can offer individualized management that may include manual therapy, which can be beneficial.
10. Exercise self-efficacy, behavior and quality of life by encouraging patients to make and maintain meaningful activities and interests through goal setting and activity planning.



Self-management of persistent pain

It has been estimated that people with health conditions (including pain) may spend less than 3 hours a year on average in contact with members of their healthcare team; therefore, the need to learn self-management skills, as well as seeking the help of healthcare professionals, is very important.

Patients often feel helpless and unable to cope with pain themselves.

The Pain Toolkit is a very useful resource to set the scene with patients:

- Acceptance of the pain and recognition of the need to take control is an important part of self-management
- Goal setting, pacing, planning and prioritising daily activities help patients maintain motivation and increase their activity without causing significant fluctuations in pain levels
- Relaxation and mindfulness can help ease tension in the muscles and mind
- In some cases, lack of activity worsens deconditioning to the point where any movement becomes painful; patients should be encouraged to maintain a level of activity



Prescribing in persistent pain



Prescribing in pain management and opioids

Complete pain relief is rarely achieved with opioids; the goal of pain management should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning

The decision to start long-term opioid therapy should be considered carefully by the patient and the prescriber, and arrangements for long-term monitoring must be in place

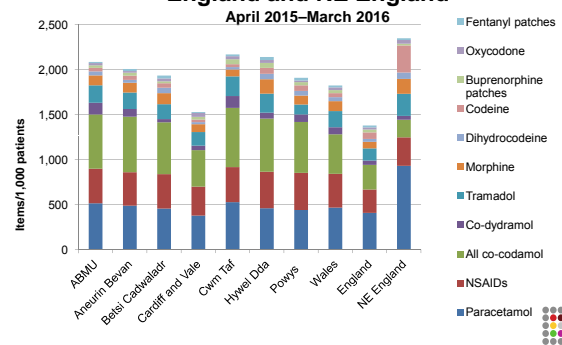
The prescribing of opioids can result in problem drug use and the likelihood of this occurring can be influenced by social, psychological and health related factors

Any concerns about problem drug use should prompt referral to specialised pain and addiction services

Resources should be available to prescribers in non-specialist settings to empower clinicians by supporting the evidence-based decisions they make within the complex context of multidisciplinary pain management



Opioid and other analgesic prescribing breakdown for health boards in Wales, England and NE England



Dose equivalences

The following slides provide examples from the BNF of dose equivalence tables of some commonly prescribed opioids

Equivalence tables may differ locally

Refer to local guidelines when appropriate



Equivalent doses of opioid analgesics

Analgesic	Route	Dose
Codeine	PO	100 mg
Diamorphine	IM, IV, SC	3 mg
Dihydrocodeine	PO	100 mg
Hydromorphone	PO	2 mg
Morphine	PO	10 mg
Morphine	IM, IV, SC	5 mg
Oxycodone	PO	6.6 mg
Tramadol	PO	100 mg



Fentanyl patch equivalences

72-hour fentanyl patches are <i>approximately</i> equivalent to the following 24-hour dose of oral morphine*.		
morphine salt 30 mg daily	≡	fentanyl '12' patch
morphine salt 60 mg daily	≡	fentanyl '25' patch
morphine salt 120 mg daily	≡	fentanyl '50' patch
morphine salt 180 mg daily	≡	fentanyl '75' patch
morphine salt 240 mg daily	=	fentanyl '100' patch

*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.



Buprenorphine patch equivalences

Buprenorphine patches are <i>approximately</i> equivalent to the following 24-hour dose of oral morphine*.			
morphine salt 12 mg daily	≡	BuTrans® '5' patch	7-day patches
morphine salt 24 mg daily	≡	BuTrans® '10' patch	7-day patches
morphine salt 48 mg daily	≡	BuTrans® '20' patch	7-day patches
morphine salt 84 mg daily	≡	Transtec® '35' patch	4-day patches
morphine salt 126 mg daily	≡	Transtec® '52.5'	4-day patches
morphine salt 168 mg daily	≡	Transtec® '70' patch	4-day patches

*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.



Opioids

Ten Key Messages - Strong Opioids

- There is a good evidence base for the use of strong opioids on acute and chronic pain. There is very little evidence for their use in long term pain.
- Resistant pain may not be a sign of disease, so increasing the dose may have no benefit on the pain.
- Complete pain relief is rarely achieved. The goal of therapy should be to reduce symptoms enough to support important quality of life, social and emotional functioning.
- 80% of patients taking opioids will have at least one adverse effect* and should be monitored and given prescriptive advice.
- Choosing advice - the patient should be advised not to drink alcohol at the start of therapy, and when doses are increased they should only have alcohol if they feel fit to do so. It is their responsibility to inform the GP that they are taking such medications (see [Drug Interactions](#) for further information).
- Patients must be made aware of the long-term effects of opioids on the endocrine and immune systems.
- If possible, consider using modified release preparations. Due to the wide range of modified release preparations available, caution should be exercised to ensure the correct product is selected.
- Intermittent formulations should NOT be used to manage chronic pain. Immediate release preparations should only be used for short periods of breakthrough pain and should be stopped as soon as possible as they have a higher incidence of addiction.
- If patients have been treated by 100 mg or more oral morphine equivalent per 24 hours with no benefit, specialist referral in adults is recommended.
- Fentanyl and buprenorphine patches can be used as a rescue and are should be prescribed in persistent pain when there is a good clinical indication to use them, e.g. patient unable to swallow.



Strong Opioid Prescribing

Strong opioid use a whole is increasing within NHS Wales

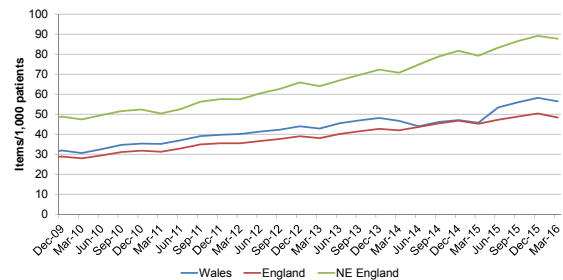
The number of prescription items of strong opioids in Wales has increased by 46%* over the last few years

The number of prescription items for strong opioids increased by 11% over the last year**



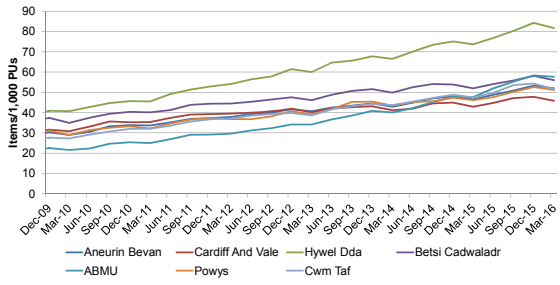
Strong opioid prescribing trends for Wales, England and NE England

Quarter ending December 2009–Quarter ending March 2016

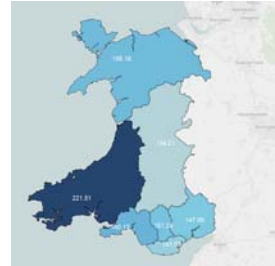


Strong opioid prescribing trends for Welsh health boards

Quarter ending December 2009–Quarter ending March 2016



Strong Opioids – Items per 1,000 PUs



Morphine as a percentage of strong opioid prescribing

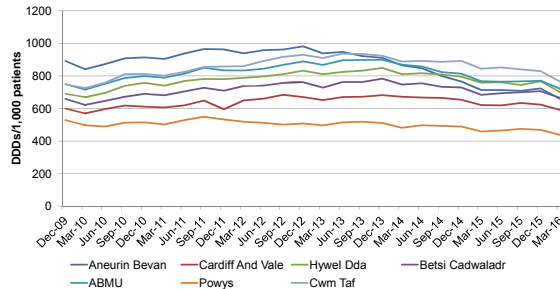


Tramadol

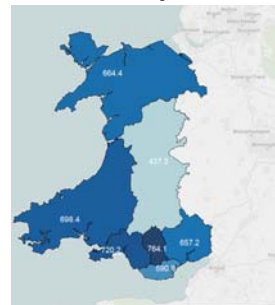


Tramadol prescribing trends for Welsh health boards

Quarter ending December 2009–Quarter ending March 2016



Tramadol – DDDs per 1,000 patients

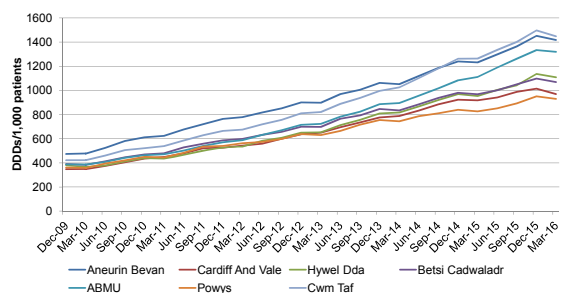


Neuropathic agents



Gabapentin and pregabalin prescribing trend for Welsh health boards

Quarter ending December 2009–Quarter ending March 2016



Ten Key Messages - Treatment of Neuropathic Pain

- Neuropathic pain is caused by dysfunction of peripheral nerves sending incorrect signals to the brain. It can have a metabolic, infectious, traumatic, inflammatory/autoimmune, vascular, idiopathic or neurodegenerative cause.
- The pain can be spontaneous, continuous, intermittent, superficial or evoked. It can be made worse by temperature or touch.
- It can be described as burning, stinging, shooting, itching, pins and needles, or numbness in terms of normal reference.
- Assessment tools such as the [DN4](#) and [PainDETECT](#) can be used to assist diagnosis. See Appendix 5 in the main document for other examples.
- [NICE](#) has provided guidance with regards to management of neuropathic pain. Check whether an anticonvulsant, antidepressant or analgesic is appropriate for generalised neuropathic pain. Consideration should be given to the need for a trial of gabapentin or pregabalin. See also the main document for other examples.
- General pain management advice can be given as per the [NICE](#).
- If at any stage, as in the underlying disease process, the following investigations should be considered: renal and liver function, ESR, rheumatoid factor, haemoglobin, urea, FBC, vitamin B12, LFT, VEGF, ANCA, appropriate serology.
- Pain may not be sufficient to require an if pain persists despite increasing doses of regular, [NSAID](#) or analgesic.
- Change should be considered when there is a change in the pattern of pain or if the patient's response to the medication is not helping. They should be considered and discussed with the patient to ensure that it is about regular review.
- [NICE](#) also provides some [guidance](#) on considering a referral to specialist services. See also the main document for other examples.



National Prescribing Indicators

NPIs

2015-2016

Items of morphine as a percentage of strong opioid prescribing
Tramadol DDDs per 1,000 patients

2016-2017

Tramadol DDDs per 1,000 patients
Gabapentin and pregabalin DDDs per 1,000 patients



Online interactive programme for comparative analysis of NPI information

Available at <http://howis.wales.nhs.uk/sites3/page.cfm?orgid=428&pid=69110>



Information relating to harm

ONS
NPIS
YCC



Deaths related to drug poisoning in England and Wales 2014

3,346 drug poisoning deaths were registered in 2014 in England and Wales, the highest since comparable records began in 1993

Deaths involving heroin and/or morphine increased by almost two-thirds between 2012 and 2014, from **579** to **952** deaths

Deaths involving tramadol have continued to rise, with **240** deaths in 2014

In England there was a **17%** rise in the drug misuse mortality rate in 2014 to **39.7** per million population, while in Wales the rate fell by **16%** to **39.0** deaths per million, the lowest since 2006



Number of drug-related deaths in England and Wales by substance

	2010	2011	2012	2013	2014
All drug poisoning deaths	2,747	2,652	2,597	2,955	3,346
Heroin and morphine	791	596	579	765	952
Methadone	355	486	414	429	394
All amphetamines	56	62	97	120	151
MDMA/Ecstasy	8	13	31	43	50
PMA/PMMA	0	1	20	29	24
Novel psychoactive substances	22	29	52	60	67
All benzodiazepines	307	293	284	342	372
Diazepam	186	179	207	228	258
Zopiclone/zolpidem	67	71	83	86	100
All antidepressants	381	393	468	466	517
Tricyclic antidepressants (BNF 4.3.1)	194	200	233	235	253
Selective serotonin re-uptake inhibitors (SSRIs) (BNF 4.3.3)	136	127	158	150	159
Other antidepressants (BNF 4.3.2 and 4.3.4)	74	84	104	123	155
Paracetamol	199	207	182	226	200
Tramadol	132	154	175	220	240
Codeine	91	88	73	130	136
Dihydrocodeine	90	109	103	102	86
Other specified opiate	66	90	80	93	129
Unspecified opiate	172	131	92	145	169



Telephone enquiries to the National Poisons Information Service (NPIS) 2014–2015

Substance	Number of telephone enquires	Ranked
Tramadol	659	8
Morphine	248	20
Gabapentin	278	31
Pregabalin	435	18
Methadone	74	N/A



Thank you



AWTTC
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& Toxicology Centre